Long-Term Care Hospital Prospective Payment System Proposed Rule Frequently Asked Questions and Answers

1. On-Site Discharges and Readmittances

1.1 Question: On pages 13462 - 13463 of the LTCH PPS proposed rule, CMS discusses a proposed policy for discharges to acute care facilities of hospital-within-hospitals (HWHs). Specifically, CMS states "… during a cost reporting period, if the hospital-within-hospital discharges more than 5 percent of its inpatients to the acute care hospital where it is located, and those patients are readmitted to the excluded hospital, Medicare considers each patient's entire stay as one discharge for purposes of calculating the cost per discharge of the excluded hospital." What is the term "excluded" being referred to in this context.

Answer: The statement cited refers to existing regulations at 413.40(a)(3), which established a policy under the TEFRA payment system applicable to PPS-excluded hospitals, such as LTCHs, rehabilitation and psychiatric hospitals, which were co-located as hospitals-within-a-hospital with an acute care hospital. (See the July 30, 1999 Federal Register, 64 FR 41535).

1.2 Question: Are the "5 percent rules" for onsite discharges and readmittances between LTCHs and other co-located facilities discussed on pages 13462 – 13463 of the LTCH PPS proposed rule in lieu of the proposed interrupted stay policy discussed on pages 13455 - 13462 of the LTCH PPS proposed rule?

Answer: The "5 percent rules" for onsite providers under proposed §412.532 are not in lieu of the interrupted stay policy under proposed §412.531. If discharges and readmittances from a LTCH to a co-located acute care hospital or to other co-located Medicare sites of care exceed the 5% thresholds described in the proposed rule, all such stays will be treated as one discharge regardless of the length of stay at the intervening facility. If the 5 percent threshold is not exceeded, the proposed interrupted stay policy will still apply to any discharge and readmittance between a LTCH and other co-located facilities.

2. Payment Rates

2.1 Question: What adjustments are included in the proposed standard Federal payment rate of $27,649.02 discussed on pages 13469 - 13472 of the LTCH PPS proposed rule?

Answer: As thoroughly discussed on pages 13469 through 13473 of the LTCH PPS proposed rule, the proposed standard Federal payment rate of $27,649.02 has already been adjusted for budget neutrality, the behavioral offset, and the high cost outlier pool, but not the costs associated with the proposed 5-year transition period.

3. Market Basket Update

3.1 Question: In the rate setting file posted on the web, operating costs are described as the "Estimated operating cost per case based on cost report data trended forward to FY 2003 using historical cost report data." What does the term "trended forward" refer to?

Answer: Operating costs from the most recent available cost report data (either FY 1999 or FY 1998) were trended forward to estimate FY 2003 costs using the most recent estimates of the excluded hospital market basket percent increases of 2.4 percent for FY 1999, 2.9 percent for FY 2000, 3.4 percent for FY 2001, 3.3 percent for FY 2002, and 3.6 for FY 2003.

4. The LTC-DRG Grouper

4.1 Question: CMS states that to calculate the proposed relative weights, it obtained charges from Medicare bill data in the FY 2000 MedPAR files and it used version 18.0 of the CMS GROUPER (used under the hospital inpatient prospective payment system for FY 2001). Are the DRGs listed in the FY 2000 MedPAR files correct or does the Version 18 GROUPER have to be applied to the data?

Answer: Each LTCH claim in the FY 2000 MedPAR file was assigned a LTC-DRG using the ICD-9 diagnosis and procedure codes and other information (age, sex, etc.) on the claim. The specific DRG listed in the FY 2000 MedPAR file for each claim was not used.

4.2 Question: Is the Version 18 GROUPER program available for correct LTC-DRG assignment for MedPAR FY 2000 data?

Answer: 3M/Health Information Systems (HIS) is under contract with CMS and is responsible for updating and maintaining the CMS-DRG GROUPER program, which is used by all Medicare acute care inpatient hospitals. A copy of the Version 18 GROUPER program can be obtained by contacting 3M/HIS in writing at the following address: 100 Barnes Road, Wallingford, CT 06492; or by phone at (203) 949-0303. Please specify the version requested.

5. Relative Weights

5. 1 Question: On page 13441 of the LTCH PPS proposed rule, in Step 1 of "Calculating the Proposed Relative Weights," CMS states that the result of step 1 is that "each LTCH's average cost per discharge is adjusted..." Should this read, "…each LTCH's average *charge* per discharge...?"

Answer: This was an error. The proposed LTC-DRG weights were calculated based on average charges per discharge. Please see question 5.8 for an additional correction to "Calculating the Proposed Relative Weights" on page 13441 of the LTCH PPS proposed rule.

5.2 Question: On page 13437 of the LTCH PPS proposed rule, CMS states that charges are standardized by dividing the charge for the case (adjusted for short-stay outliers) by the average charge for all cases at the LTCH in which the case was treated. This ratio is then multiplied by the LTCH's case-mix index to determine the standardized charge for the case. Does this mean "charge weight" and not just "standardized charge"?

Answer: Yes. The ratio of the charge for each case to the average charge (adjusted for short-stay outliers) for all cases at the LTCH is then multiplied by the LTCH's case-mix index to determine the standardized "charge weight" for the case.

5.3 Question: Are the following steps the correct specification of the calculations described in the LTCH PPS proposed rule for determining the LTC-DRG relative weights?

Calculate a hospital-specific relative charge value:

Divide the short-stay outlier adjusted charge per case (after removing the statistical outlier) by the average charge per case for the LTCH in which the case occurred.

b. Multiply the ratio obtained in (a) by the LTCH's case-mix index to obtain an adjusted hospital-specific relative charge value for the case.

c. An initial case-mix value of 1.0 is used to initiate the iterations.

Calculate LTC-DRG relative weights:

d. Divide the average of the adjusted hospital-specific relative charge values for the LTC-DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. This is the new LTC-DRG recalculated weight.

e. Divide the sum of all the LTCH's LTC-DRG relative weights by its total number of equivalent cases (i.e. adjusted for short-stay outliers). This is the LTCH facility's average relative weight for all of its cases (their case-mix index) .

f. Multiply the LTCH facility's hospital case mix index by the LTCH's relative charge values. These values are the hospital-specific case-mix adjusted relative charge values.

g. Calculate a new set of LTC-DRG relative weights across all LTCHs.

h. Continue steps a) through e) above.

Continue this iterative process until there is convergence or the maximum difference between the recalculated weights is less than .0001.

Answer: Yes, this is an accurate description of the calculations described used to determine the LTC-DRG relative weights using the hospital-specific relative value methodology.

5.4 Question: In step e above, is this case-mix index weighted for the number of cases in each LTC-DRG?

Answer: Yes. The case mix index is weighted for the number of equivalent cases (i.e. adjusted for short-stay outliers) in each LTC-DRG. As we stated on page 13441 of the LTCH PPS proposed rule, short-stay outliers were counted as an "equivalent case" or a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the LTC-DRG for nonshort-stay outlier cases.

5.5 Question: In step f above, is this calculation done for each LTC-DRG?

Answer: Yes. The relative charge values are determined on a case by case basis, such that the LTCH's case-mix index is multiplied by the LTCH's relative charge values for each case.

5.6 Question: On page 13442 of the LTCH PPS proposed rule, CMS states "…cases classified to the proposed LTC-DRG "with CCs" of a "with CC"/"without CC" pair had a lower average charge than the corresponding proposed LTC-DRG "without CCs."" It is not clear what is being referred to here. Is this statement saying that identical cases were classified into both categories (with and without CCs) and the "with CC" category was found to have lower charges than the "without CC category?"

Answer: This statement means that using the LTCH claims data in the FY 2000 MedPAR files to assign each LTCH case a LTC-DRG, we found that the LTC-DRG "with CC" had a lower average charge than the corresponding LTC-DRG "without CCs." Based on the LTCH cases in the FY 2000 MedPAR files, we found ten pairs of LTC-DRGs with nonmonotonically increasing relative weights. For example, LTC-DRG 10 (Nervous System Neoplasms With CCs) was found to have a lower relative weight than LTC-DRG 11 (Nervous System Neoplasms Without CCs) based on the claims data for LTCH cases in the FY 2000 MedPAR files.

5.7 Question: Do short-stay outliers receive equal weight in the relative weight calculations? In other words, is a short-stay outlier case treated the same as an inlier case for the purposes of calculating relative charge weights?

Answer: In the relative weight calculations, inlier cases are treated as a full case, while short-stay outliers are counted as a fraction of a case (equivalent) based on the ratio of the length of stay of the case to the average length of stay of the LTC-DRG for non-short stay outlier cases. In calculating the standardized relative charge values, the sum of all of the adjusted relative charge weights is divided by the sum of equivalent cases.

5.8 Question: CMS states that discharges greater than 3.0 standard deviations from both the mean log distribution of charges per case and charges per day for each LTC-DRG are considered statistical outliers and are excluded before relative payment weights are calculated. Are these statistical outliers removed before or after short-stay outlier cases are adjusted?

Answer: Statistical outliers were removed before short-stay outlier cases are adjusted. Please note that the order of Step 1 and Step 2 of "Calculating the Proposed Relative Weights," on page 13441 of the LTCH PPS proposed rule, were inadvertently reversed.

6. Payment-to-Cost Ratios

6.1 Question: What is the definition of "payment-to-cost" ratio in terms of MedPAR and cost report variables? Does this phrase refer to the "reimbursed amount (from the

MedPAR reimbursement variable) to cost" (MedPAR charges times cost-to-charge ratios obtained from the cost report)?

Answer: "Payment-to-cost" ratios were calculated by dividing the simulated payment for each case under the proposed LTCH PPS by the estimated cost of the case. The estimated cost of the case was determined by multiplying the covered charges from the FY 2000 MedPAR file by the LTCH's cost-to-charge ratio. The "reimbursed amount" field from the MedPAR file was not used to determine the payment for each case and the cost-to-charge ratios from the cost report were not used to determine cost of each case. (See #7 below for further clarification of the cost-to-charge ratios.)

7. Cost-to-Charge Ratios

7.1 Question: CMS states that in computing hospital-specific cost-to-charge ratios (CCRs), costs from the most recent available cost report were "matched" to claims data from the MedPAR files. How were the CCRs computed by "matching" cost report and MedPAR data?

Answer: The CCRs were determined by dividing the average cost per case from the LTCH's most recent available cost report by the LTCH's average covered charge per case from MedPAR data for the same months as the months covered by the cost reporting period. For example, for a LTCH with a 12-month cost reporting period beginning on July 1, 1999 and ending on June 30, 2000, we used MedPAR data for claims discharged from July 1999 through June 2000 to compute its CCR.

7.2 Question: Was an inflation factor used in determining the cost-to-charge ratios (CCRs) referred to in the proposed rule and shown in the rate setting file posted on the web?

Answer: We did not apply an inflation factor to the CCRs. In determining the CCRs, costs were taken directly taken from the cost report and covered charges were taken directly from the MedPAR files.

7.3 Question: Do the cost-to-charge ratios (CCRs) already reflect the qui-tam adjustment discussed on pages 13469-13470 of the LTCH PPS proposed rule?

Answer: The qui-tam adjustment was not applied to the costs from the cost report used in determining the CCRs.

7.4 Question: On page 13455 of the LTCH PPS proposed rule, CMS states that the cost of the case for determining payment for short-stay outlier cases would be determined by applying the LTCH's cost-to-charge ratio to the LTCH's allowable Medicare charges. When determining the cost of the case, which cost-to-charge ratio (CCR) was used and was it applied to the charges incurred up to discharge?

Answer: In determining the cost of the case for a short-stay outlier case, the CCR was calculated as described above. The CCR was applied to the covered charges from the FY 2000 MedPAR file to determine the cost of each short-stay outlier case.

8. Calculations of Operating and Capital Costs

8.1 Question: How were the average operating and capital cost per case calculated from cost report variables?

Answer: Using data from the cost report, the average operating cost per case was determined by dividing total Medicare inpatient operating costs for the cost reporting period from Worksheet D-1, adjusted by the qui tam factor (as discussed on pages 13469 – 13470 of the proposed rule), by the total number of Medicare discharges for the same cost reporting period from Worksheet S-3. Similarly, the average capital cost per case was determined by dividing total Medicare inpatient capital costs for the same cost reporting period from Worksheets D, Part I and Part II by the total number of Medicare discharges for the cost reporting period from Worksheet S-3.

8.2 Question: In the rate setting file posted on the web, are the operating and capital cost per case representative of adjusted cost report FYs 1998 and 1999 total operating cost and total capital cost divided by the number of cases for FYs 1998 and FY1999 as found in the respective cost reports?

Answer: Yes. As explained above, the operating and capital costs per case were determined by dividing total Medicare inpatient operating and capital costs from the cost report, adjusted by the qui tam factor (as discussed on pages 13469 – 13470 of the proposed rule), by the total number of Medicare inpatient discharges from the same cost report.

8.3 Question: Were estimated FY 2003 capital payments based on 100 percent of capital costs?

Answer: Yes. We based FY 2003 capital payments on 100 percent of capital costs because the 15 percent capital payment reduction established by the BBA, was applicable for cost reporting periods beginning on or after October 1, 1997 and before October 1, 2002.

9. Transition Period

9.1 Question: During the proposed transition period, will a LTCH that is paid under the proposed phase-in blended method be paid 100 percent of its capital costs?

Answer: During the proposed transition period, a LTCH that is paid under the proposed blended method would be paid 100 percent of its capital costs for the TEFRA portion of its transition period payment. For the PPS portion of its transition period payment, capital costs would be paid based on the standard Federal rate, which accounts for both operating and capital costs.

9.2 Question: During the proposed transition period, will a LTCH that is paid under the proposed phase-in blended method be eligible for the existing TEFRA Bonus and Continuous Improvement Bonus payments?

Answer: During the proposed transition period, a LTCH that is paid under the proposed blended method would be eligible for the existing TEFRA Bonus and Continuous Improvement Bonus payments as set forth under §413.40(d)(4) for the TEFRA portion of its transition payment.

10. Data Analysis

10.1 Question: If there were 252 LTCHs in December 2000 and 270 LTCHs in November 2001, as CMS states on page 13419 of the LTCH PPS proposed rule, why were only 222 LTCHs used for the analysis in the LTCH PPS proposed rule? Some LTCHs data were excluded from the rate calculations and the LTC-DRG relative weights.

Answer: As we state on page 13465 of the LTCH PPS proposed rule, our analyses were based on data from 222 LTCHs for which both cost and case-mix data were available.

10.2 Question: Were covered charges (and covered days) or total charges (and total length of stay) used in the determination of the LTC-DRG relative weights payment rates?

Answer: Covered charges and covered days were used in the determination of the both the LTC-DRG relative weights and the payment rates.

10.3 Question: Which rate setting file variables reflect updated cost report information beyond FY 1998 and FY 1999 cost reports and how was this updated cost report information applied in the rate setting formulas?

Answer: As clearly stated on page 13470 of the LTCH PPS proposed rule, all cost report and payment data in the rate setting file that we published in our proposed rule reflect FY 2003 updates.

10.4 Question: In the rate setting file posted on the web, the variable "PPS Payments (Excluding Outlier Payments)" which is described as the "Estimate of payments under the proposed LTCH PPS for cases in the FY 2000 MedPAR by applying the proposed payment methodologies for Very Short Stay Discharges and Short-Stay Outliers but excluding Outlier payments," which method was used to determine this variable: applying proposed payment methodologies for very short-stay discharges and short-stay outliers or using the variable "Number of Equivalent MedPAR Cases" and the variable "Case Mix Index"?

Answer: In the rate setting file and in Step e (Estimate Payments Under the Proposed PPS Without a Budget Neutrality Adjustment) of the "Development of the Standard Federal Rate" on page 13471 of the LTCH PPS proposed rule, we estimated "PPS Payments" for each provider by simulating payments on a case by case basis by applying the proposed payment methodologies for very short-stay discharges (as discussed on page 13454) and short-stay outliers (as discussed on pages 13455). A reasonable proxy for estimated PPS Payments under the proposed LTCH PPS can be determined by using the variable "Number Equivalent MedPAR Cases" and the variable "Case-Mix Index" in the rate setting file, which were adjusted for short-stay outliers by counting them as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay of the LTC-DRG for non-short stay outlier cases. However, this fractional adjustment for short-stay outliers was not used to determine the payment for those cases in determining estimated total PPS payments in the rate setting file or in the determination of the proposed standard Federal rate.

10.5 Question: On page 13445 of the LTCH PPS proposed rule, the arithmetic mean length of stay (LOS) is given for each LTC-DRG in Table 4. In calculating the arithmetic mean LOS for each LTC-DRG, was there any adjustment for the short-stay outlier cases?

Answer: No. The arithmetic mean LOS for each LTC-DRG was calculated by summing the LOS for each case in the LTC-DRG and dividing by the respective number of cases.

10.6 Question: On pages 13445 – 13453 of the LTCH PPS proposed rule, Table 4 gives the number of cases from the FY 2000 MedPAR files assigned to each LTC-DRG in determining the relative weights and average length of stay. According to the column of the number of "FY 2000 LTCH Cases" in Table 4, the total number of cases used to determine the LTC-DRG relative weights were 89,014. Did all of these cases come from the FY 2000 MedPAR files or were cases added from some other source?

Answer: All of the cases used to determine the relative weights for the LTC-DRGs in Table 4 were from the FY 2000 MedPAR file, but the total number of cases used to determine the LTC-DRG relative weights was 78,110. Although Column 5, FY 2000 LTCH Cases, is not accurate for a number of LTC-DRGs, the underlying model did use the correct number of cases for each LTC-DRG. A revised version of Table 4 with the correct number of cases in Column 5 for each LTC-DRG has been posted on the CMS web site at http://www.hcfa.gov/medicare/ltchpps.htm.

11. High Cost Outliers

11.1 Question: If a patient is a high cost outlier but has a length-of-stay (LOS) that is less than 2/3 of the average LOS of the LTC-DRG, is the patient reimbursed under the high cost outlier policy and if so, would the full LTC-DRG be covered first or only the payment for the patient being a short-stay outlier would be paid first?

Answer: **Cases that have a LOS of 7 days or less (a very short-stay discharge) are eligible for high cost outlier payments. Cases that have a LOS between 8 days and 2/3 of the average LOS of the LTC-DRG (short-stay outliers) are also eligible for high cost outlier payments if the discharge is paid based on 150 percent of the LTC-DRG per diem amount or the full LTC-DRG payment. Short-stay outlier cases that are paid 150 percent of costs are not eligible for high cost outlier cases since the LTCH is already receiving a LTCH PPS payment that covers the cost of that case. In determining a high cost outlier payment for very-short-stay discharges and eligible short-stay outlier cases, the full LTC-DRG payment would used in determining the outlier threshold and subsequently high cost outlier payments.**

11.2 Question: The "Outlier Payments" variable is defined as, "Estimated Outlier Payments determined using FY 2000 MedPAR Cases and the Cost-To-Charge Ratio." Was the CCR applied to charges from the MedPAR data and the outlier costs determined per case?

Answer: **CMS applied the cost-to-charge ratio to charges from the MedPAR in order to determine per case outlier costs.**

11.3 Question: If the charges of the statistical outliers were removed before determining hospital-specific relative value units, how does the outlier policy account for differences in hospital charges?

Answer: **Statistical outliers are a method for removing "bad" data. The outlier policy is meant to account for the higher costs for cases that reflect more costly patients rather than bad data.**

12. Data Availability

12.1 Question: Is it possible to get the LTCH PPS impact file with provider number, cost per case, total discharges (adjusted for short stay outliers), wage index, DSH, and teaching variables, etc.?

Answer: **CMS has posted a Rate Setting File and an Adjustment File on the web at http://www.hcfa.gov/medicare/ltchpps.htm. The Rate Setting File includes all of the variables required to determine the proposed standard Federal rate and perform hospital-level impact analysis based on the proposed LTCH PPS. The Adjustment File includes all of the variables used in considering potential payment system adjustments for the LTCH PPS proposed rule.**